PUBLIC-PRIVATE ISSUES AND ACCESS*

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LET ME BE PROVOCATIVE and point out that the title of the session, "Restructuring Health Services in the City," is something of an oxymoron. No individual or agency—neither the mayor, the Health and Hospitals Corporation, the Health Commissioner, the academic health centers, the voluntary hospitals, nor the community health clinics, has such a charge; and if it had, little could be done about it. I have reached this conclusion in part as a result of my participation on the recent New York City Child Health Commission—my first direct exposure to the local government agencies—which convinced me that the reform of the bureaucracy, while in theory doable, will in practice turn out to be an exercise in frustration.

If we were living in different times, when money was available in large amounts, I might have concluded otherwise because money, especially lots of new money, can help to unfreeze frozen interdepartmental relationships. But in the absence of new money I seriously question that structural reforms can be introduced on a sufficiently broad scale and within a reasonably contained period for outcomes to be improved in real time. The Commission found that the city spends an astronomic $1.2 billion of public funds to provide health services for 1.2 million poor children, and yet many of the recipients get indifferent, if not poor, care and many others slip between the cracks. That is sufficient cause for pessimism.

I come to today's subject—improving primary care services in low income neighborhoods—with perceptions informed by direct experience with my assigned topic. Specifically, the Conservation of Human Resources Project that I direct at Columbia published in the mid-1980s two books, each of which has something to contribute to today's inquiry. The first, entitled *Local*

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Health Policy in Action: The Municipal Health Services Program,[1] was a thorough, concurrent evaluation of a five year-five city demonstration sponsored by the Robert Wood Johnson Foundation with a grant of 15 million dollars. The aim of the project was to strengthen local community health centers so that low income residents could obtain more and better health care than by crowding the emergency rooms and clinics of municipal and voluntary hospitals. For a variety of reasons we concluded that the concept, though sound, was difficult to implement and that on balance the outcome was no better than a draw.

The other work of the Conservation Project relevant to today's theme was our volume entitled *From Health Dollars to Health Services: New York City 1965–1985.*[2] Although the city lost 10% of its population during these two decades, its total expenditures for health care increased by about 250% in *real* dollars. Our effort traced who got the money and who got the additional services. It would take me too far afield to recount in detail the principal findings, but the most important one for today's discussion is that relatively little of the sizable new funds actually went to improving the quality of ambulatory care for poor people.

So much for setting the stage. I plan in my presentation first to set forth the realities that determined the availability of neighborhood health care services in this city, and then to advance a limited number of *modest* suggestions that might help to improve service delivery to groups most in need of more and better care.

In brief review: In many neighborhoods in New York most of the residents have sufficient income to obtain the ambulatory care they want and need from private practitioners. They confront no special difficulty in finding practitioners who are willing to treat them. In short, both patients and physicians are more or less satisfied with each other. These more affluent neighborhoods need no special attention or action. However, other areas, chiefly those with concentrations of low-income residents, have a severe shortage of practitioners. If my recollection is correct, some years ago there was not one pediatrician left in full-time private practice in Harlem.

As for community health centers, there are about 35 to 40 still operating in the city but no more than 10 function in a way they and their patients would consider satisfactory. Most have serious difficulties in attracting and retaining staff, and the staff that they do have are often unable to follow their patients when they are admitted to local hospitals, among other reasons because of lack of adequate liability insurance. Moreover, many of these clinics are in serious physical disrepair and lack critical equipment.

It would be overkill to reemphasize the extent to which the emergency rooms and the clinics of most of the Health and Hospitals Corporation facili-

ties are stressed in terms of volume, staffing, physical surroundings, poor equipment, inadequate data systems, and many other deficiencies.

Finally, there are the ambulatory care services of the voluntary hospitals, many of which provide large amounts of care for poor people who live in their immediate neighborhoods. The worsening financial outlook of these voluntary hospitals is attributed to their large volume of uncompensated care.

The congruence of weakened health clinics, a stressed municipal hospital system, and voluntary hospitals that are racing toward bankruptcy because of the volume of unreimbursed ambulatory service that they provide have serious consequences for the care that is received by the poor and the needy. Many individuals fail to enter the system before their conditions have become seriously aggravated as the result of prior neglect; there is a lack of continuity and comprehensiveness in the care that is received, and this is particularly dysfunctional for the health of children; there is considerable slippage with respect to referrals, so that many patients who should be evaluated and treated by specialists fail to be seen; and preventive services are neglected as institutions and personnel are overextended in trying to cope with patients who present with emergent conditions.

The foregoing are not minor deficits. They are serious and warrant attention and correction. As a contribution to the improvement of health care for the poor, I offer several modest suggestions.

Since I postulate that most of the poor will continue to seek care from their neighborhood hospitals, the first challenge is to upgrade the operations of the emergency rooms which are currently the principal sites of care. It would seem that what is needed is a walk-in clinic for those presenting with minor symptoms. Strengthening the hospital information system so that the physician on call could be informed promptly about the patient's prior history would contribute significantly to an improvement in quality.

Voluntary hospitals should explore the approach adopted by Presbyterian Hospital of establishing an ambulatory care network in the surrounding community. The state should support such efforts and offer hospital reimbursement rates to participating physicians.

More of the Health and Hospitals Corporation hospitals should follow Harlem Hospital's decentralization program which has established off-site clinics readily accessible to the local population. And the Health and Hospitals Corporation should assess the strengths and weaknesses of its pioneering efforts to establish a modified HMO at Coney Island Hospital to assure continuity and comprehensiveness of care for children and other family members.

The State of New York should explore different mechanisms that might be used to facilitate borrowing by established community health centers in need

of capital investments to modernize their facilities. State officials should explore the potential for providing improved malpractice coverage for physicians on the staffs of community health clinics to enable them to treat clinic patients who have been hospitalized, and the state should act promptly on its plan to increase the per visit fee for qualified practitioners from $11 to $40.

Since a growing number of the poor and needy in New York City are recent immigrants, many with little or no knowledge of English, the Commissioner of Health should explore opportunities to reach these groups through the schools, churches, and other neighborhood organizations with educational materials informing them of the range of medical services available to them.

The State of New York should review its present scholarship and loan programs for low income students who study medicine and aim to broaden the opportunities available to those who commit themselves to join the staff of a community health center or other type of practice in an underserved area on completion of their training.

Finally, the advocacy community for improved health care for the poor should press the Congress and the Department of Health and Human Services to maintain (preferably expand) their funding for proved, existing community health centers. Another step is to lobby the Congress to expand the number of entrants into the National Health Service Corps whose members currently account for a significant proportion of the staffs of community health clinics.

My concluding observations may be summarized as follows: There is a need to improve ambulatory care in low income areas of the city. Such improvement must take into consideration the fact that, in general, physicians avoid establishing practices in poor neighborhoods. Accordingly, the main thrust of the reforms must be to improve the ambulatory care currently provided by the municipal and voluntary hospitals located in or close to low income neighborhoods. Some effort should be directed to maintaining and improving the viability of community health clinics currently meeting significant needs in their areas. Efforts to improve the quantity and quality of health care services for the poor and the needy must never lose sight of the fact that more jobs, more income, more security, and more hope can also make major contributions to the health and well-being of the poor.

REFERENCES

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2. Ginzberg, E. and the Conservation of Human Resources staff: *From Health Dollars to Health Services: New York City 1965–1985.* Totowa, NJ, Rowman & Allanheld, 1986.